Maryland Institute For
Emergency Medical Services Systems

Short Form Patient Information Sheet 2012

Jurisdiction: _____ **Date:** _____
Incident # _____ **Time Arrived at Hospital:** _____
Unit #: _____
Age: _____ **DOB:** _____ **Wt:** _____ **Kg** **Gender:** ❑M ❑F
Priority: ❑1 ❑2 ❑3 ❑4 **Trauma Category:** ❑A ❑B ❑C ❑D
Patient's Name: _____
Patient's Address: _____
City: _____ **State:** _____
Point of Contact: _____ **Phone Number:** _____
Chief Complaint: _____
Time of Onset: _____ **Past Medical History: (DNR/MOLST ❑A1 ❑A2 ❑B)**
Cardiac ❑ CHF ❑ Hypertension ❑ Seizure ❑ Diabetes ❑ COPD ❑ Asthma ❑
Other: _____
Current Meds: _____ _____ _____ _____
_____ _____ _____ _____ _____
Allergies: **Latex ❑ Penicillin/Ceph ❑ Sulfa ❑ Other:** _____

Assessments

Vitals
Time: _____
B/P: _____ / _____
Pulse: _____
Respirations: _____
SAO2: _____%
Capnography: _____
Carbon Monoxide: _____

Repeat Vitals
Time: _____
B/P: _____ / _____
Pulse: _____
Respirations: _____
SAO2: _____%
Capnography: _____
Carbon Monoxide: _____

Respiration

Left		Right
❑	Clear	❑
❑	Rales	❑
❑	Labored	❑
❑	Stridor	❑
❑	Rhonchi	❑
❑	Wheezes	❑
❑	Decreased	❑
❑	Agonal	❑
❑	Absent	❑

Pulse
❑ Regular ❑ Irregular
❑ JVD ❑ Peripheral Edema
Cap Refill: _____ seconds

Skin
❑ Warm
❑ Hot
❑ Cool
❑ Dry
❑ Clammy
❑ Diaphoretic
❑ Cyanotic

GCS
Eyes (4): _____
Verbal (5): _____
Motor (6): _____
TOTAL: _____

Pupils
❑ PERRL
❑ Unequal
❑ Fixed/Dilated

Neuro
❑ A ❑ V
❑ P ❑ U

Assessment

Procedures

Cardiac Rhythm:
_____
12 Lead Transmit Yes ❑ No ❑
Perform 12 Lead Yes ❑ No ❑
Glucometer:
_____
❑IV1 ❑IV2
❑IO ❑EJ
Amount Infused:
_____

CPR Performed Yes ❑ No ❑
ROSC Yes ❑ No ❑
Induced Hypothermia Yes ❑ No ❑

Cincinnati Stroke Scale
Normal/Abnormal
Facial Droop Normal ❑ Abnormal ❑
Arm Drift Normal ❑ Abnormal ❑
Speech Normal ❑ Abnormal ❑
Last Known Well Time/Date: _____

Oxygen
❑ NRB Mask ❑ King Airway
❑ Nasal Cannula ❑ CPAP
❑ NPA/OPA ❑ NDT
❑ BVM ❑ Ventilator
❑ ET ❑ NT ❑ NGT
❑ Easy Tube

Treatment:

Jurisdictional Additions:

_____
Patient Signature

_____
Receiving Facility Representative Signature and Name

Print Provider Name: _____

Section One:

When encountering a patient that is attempting to refuse EMS treatment or transport, assess their condition, and record whether the patient screening reveals any lack of medical decision-making capability (1-3,4a or b) or high risk criteria (5-8):

Medical Capacity

1. Disoriented to: Person? ❑ yes ❑ no
   Place? ❑ yes ❑ no
   Time? ❑ yes ❑ no
   Situation? ❑ yes ❑ no
2. Altered level of consciousness? ❑ yes ❑ no
3. Alcohol or drug ingestion by history or exam with:
   a. Slurred speech? ❑ yes ❑ no
   b. Unsteady gait? ❑ yes ❑ no
4. Patient does not understand the nature of illness and potential for bad outcome? ❑ yes ❑ no

If yes, transport

At Risk Criteria

5. Abnormal vital signs
   For Adults
   Pulse greater than 120 or less than 60? ❑ yes ❑ no
   Systolic BP less than 90? ❑ yes ❑ no
   Respirations greater than 30 or less than 10? ❑ yes ❑ no
   For minor/pediatric patients
   Age inappropriate HR or ❑ yes ❑ no
   Age inappropriate RR or ❑ yes ❑ no
   Age inappropriate BP ❑ yes ❑ no
6. Serious chief complaint (chest pain, SOB, syncope) ❑ yes ❑ no
7. Head Injury with history of loss of consciousness? ❑ yes ❑ no
8. Significant MOI or high suspicion of injury ❑ yes ❑ no
9. For minor/pediatric patients: ALTE, significant past medical history, or suspected intentional injury ❑ yes ❑ no
10. Provider impression is that the patient requires hospital evaluation ❑ yes ❑ no

If yes, consult

Section Two:

For providers: Following your evaluation, document information and care below:

1. Did you perform an assessment (including exam) on this patient? ❑ yes ❑ no
   If yes to #1, skip to #3
2. If unable to examine, did you attempt vital signs? ❑ yes ❑ no
3. Did you attempt to convince the patient or guardian to accept transport? ❑ yes ❑ no
4. Did you contact medical direction for patient still refusing service? ❑ yes ❑ no

Patient Refusal of EMS

I, _____, have been offered the following by _____ (EMS Operational Program) but refuse (check all that apply):

❑ Examination ❑ Treatment ❑ Transport

Patient Name: _____ Phone: _____
Patient Address: _____
Signature: _____ Witness: _____
❑ Patient ❑ Parent ❑ Guardian ❑ Authorized Decision Maker (ADM)

If you experience new symptoms or return of symptoms after this encounter, we recommend that you seek medical attention promptly.

Section Three: (CHECK ALL THAT APPLY)

Initial Disposition:

❑ Patient refused exam ❑ Patient refused treatment ❑ Patient refused transport
❑ Patient accepted exam ❑ Patient accepted treatment ❑ Patient accepted transport
❑ ADM refused exam ❑ ADM refused treatment ❑ ADM refused transport

Interventions:

❑ Attempt to convince patient ❑ Attempt to convince family member/ADM
❑ Contact Medical Direction (Facility: _____)
❑ Contact Law Enforcement ❑ None of the above available

Final Disposition:

❑ Patient refused exam ❑ Patient refused treatment ❑ Patient refused transport
❑ Patient accepted exam ❑ Patient accepted treatment ❑ Patient accepted transport
❑ ADM refused exam ❑ ADM refused treatment ❑ ADM refused transport

Section Four: (MUST COMPLETE)

Provide in the patient's own words why he/she refused the above care/service:

_____
_____
_____
_____
_____
_____
_____
_____

Jurisdiction _____ Incident: _____ Date: _____
Unit #: _____ Provider Name/EID: _____ Time: _____